Credit Card Authorization Form

Patient Name:	Date of Birth:

Credit Card Information		
Name on Card:	Card #:	
Expiration Date:	CVV #:	
Billing Address:		
City:	State:	Zip:

By signing below, I hereby authorize

PRACTICE NAME HERE

to charge the credit card listed for speech-language therapy services.

I understand that my credit card may be charged for the deductible, co-payment, or self-pay charges and that the payment amount will be based on the information that is available regarding my health insurance policy and plan.

I understand that this credit card will be charged for a missed visit fee in the event of a no-show (failure to cancel at least 24 hours before the scheduled visit).

I agree to provide notification in writing if I would like to change the credit card on file or if I would like to revoke authorization. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Signature _____ Date _____